VOL. 10—NO. 7
JANUARY 1946

The CHILD

CHILDREN'S BUREAU • U. S. DEPARTMENT OF LABOR

- What Mothers Think About Day Care
- Social Workers Look at Adoption
- Helping the Hard-of-Hearing Child

VOL. 10 NO. 7 JANUARY 1946

The CHILD

MONTHLY BULLETIN

Published by
Reports Division ● Children's Bureau

Managing Editor SARAH L. DORAN
Art Editor PHILIP BONN

CONTENTS

The photograph on the cover is by OWI Photographs on pages 108 and 109: 1, USHA, by Sekaer; 2, Rebecca Snyder; 3, USPHS; 4, OWI; 5, Murray Corp.; 6, OWI; 7, USDA; 8, Leon Trice; 9, CB; 10 OWI; 11, OWI; 12, World-Telegram, by Al. Aumuller.

Reprints of the center spread, "To Make 1946 a Banner Year for Children," are available.

U. S. DEPARTMENT OF LABOR
L. B. SCHWELLENBACH, *Secretary*
CHILDREN'S BUREAU
KATHARINE F. LENROOT, *Chief*

A JOB FOR YOU

Whether the world is to have an enduring and a just peace is going to depend in the long run upon what we do for the children, not only our own, but all children.

This Nation, like every other nation, must be concerned now about the stamina of its people and their ability to climb the long, uphill road leading to the realization of the aims for which this war was fought.

The most important long-range issues that confront us today therefore have to do with our children and youth. The kind of homes in which they are reared, the schools they attend, the communities in which they live, the spirit and purpose of the Nation as a whole, these will determine how well our responsibility to them, and to the Nation and the world, is met.

Practical steps that communities can take in meeting their responsibilities call for:

1. Housing fit for children—without this much of our planning must come to nothing.

2. Prenatal care for all mothers and child-health services for all infants and preschool children.

3. Health centers and hospitals for the whole community—well built, staffed, and equipped to give good care to all mothers and children.

4. Health programs for all school-age children and employed youth, with medical, dental, and nursing service and health education.

5. Nursery schools and kindergartens for preschool children.

6. Schooling for all children and youth, with good buildings and equipment, well-paid teachers, full terms, and well-rounded programs.

7. School lunches available to all school children, with all children treated alike—through a good school lunch we can make up to some extent for the inadequate diets many have.

8. Recreation programs for all ages.

9. Child-welfare services, well-staffed and with adequate facilities for children needing special care in their own homes or in foster homes.

10. Day-care programs for children whose mothers are employed and for all other children requiring care away from home during the day.

11. Counseling and child-labor law enforcement to help boys and girls prepare for what they want to do and find suitable jobs.

12. Good local government, mindful of the problems and needs of children and youth, with opportunity for youth to share responsibilities.

The job, of course, cannot be done by communities alone, for community resources vary. State and Federal Governments also have a responsibility, but the place to begin the job is where the children are. Every community should have within it a group of citizens officially entrusted with the responsibility for planning for its children. They must be aware, also, of the needs of children the country over, for no community can live alone. What happens to children anywhere has a direct relation to the future opportunity and well-being of all children everywhere.

While planning for our own children, we must also feel concern for the world's children, many of whom are living under hardships even greater than those suffered in the war years. We must get help to them now—all the help we can—for humanitarian reasons, which are sufficient enough. In so doing we will help them, as we help our own, toward a better world, a world in which today's children, then grown, can live in peace, freedom and security.

Katharine F. Lenroot

KATHARINE F. LENROOT,
Chief, Children's Bureau.

Publication of THE CHILD, Monthly Bulletin, with SOCIAL STATISTICS supplements from time to time, was authorized by the Bureau of the Budget, May 12, 1936, under Rule 42 of the Joint Committee on Printing, to meet the needs of agencies working with or for children for a regular channel of information on current developments, activities, policies, and programs for maintaining the health of mothers and children, providing child-welfare services, and safeguarding the employment of youth. Address THE CHILD, Children's Bureau, U. S. Department of Labor, Washington 25, D. C. The Children's Bureau does not necessarily assume responsibility for the statements or opinions of contributors not connected with the Bureau. THE CHILD is for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at $1 a year; foreign postage, 25 cents additional; single copies, 10 cents.

WHAT MOTHERS THINK ABOUT DAY CARE

Cleveland, Ohio, mothers mobilize to put a wartime service for children on a permanent basis

by *GLENNA B. JOHNSON*
Emergency Child Care Office, Cleveland

• **IF CLEVELAND, OHIO,** is any sample, there is as much chance of persuading working mothers to go back to the prewar style of day care for their children as there is of persuading a washing-machine manufacturer to go back to producing a prewar model. These working mothers not only do not want to go back; they want to work things out so they will not have to.

Trial-and-error method out of date

Through their wartime experiences they now know that there is something much better than the trial-and-error way of finding care for their children. They know that the risks their children often ran because mothers had to depend on answering or inserting ads, trying this or that commercial resource, are not inevitable. Above all they know how much better children, mothers, and families thrive when they work out their child-care problems on a community basis.

For the first time many mothers actually "shared" the care of their children in joint planning of day-care services. In many places—Cleveland was one—where day-care services included health, education, and social case work, skilled workers shared responsibility with mothers. From them mothers learned things they had not known before about the growing needs of their children. They saw their children respond to different ways of care and had a chance to talk about the behavior and reactions of their children with people trained in child development. They learned that working out child-care problems together produces results that working at them alone often failed to achieve. How well they learned all these things came out suddenly and dramatically.

On August 17 the Federal Works Agency, which had been supporting day-care centers, announced that this support would be withdrawn on October 31. It was as if a bombshell had hit Cleveland when this news became known to parents and staff on August 21. Within 10 days the mothers in over 90 percent of the day-care centers had organized, elected officers, appointed committees, and worked out a planned program of social action—city-wide, State-wide, and National in scope. Teachers and case workers were invited to sit in on their meetings. Mothers, struggling with problems of a constitution, representation, cooperation with other civic and social-welfare groups, were putting democracy into high gear.

"Through this terrible war," a Cleveland mother, addressing a group of other mothers, said, "there isn't one of us in America who hasn't promised herself a better world after all the fighting and killing is over. Now the time has come to turn these dreams and promises into action. The time is ripe and the people ready. It is up to us to offer a program and a plan for children. We know we will succeed."

What these mothers-in-action wanted was a continuing program that, unlike the emergency one which had been based on the needs of industry, was planned to meet the needs of their children. But first they had to meet the sudden curtailment of even the emergency program. To muster community support for their day-care program mothers went calling on the leading citizens and groups of the city—clergymen, businessmen, labor leaders, the Welfare Federation, officials of the city and county government. They sent a delega-

SAFE AND HAPPY at the day-care center, these youngsters think the teacher's big picture book is pretty nice; all except one, who is wishing for naptime.

OWI photograph by Marjory Collins

677907—46

tion to the Governor and two representatives to Washington who interviewed all the Congressmen and Senators from Ohio. Other mothers secured radio time for an interpretive skit and innumerable spot announcements and wrote up their case for the newspapers. A mass meeting was organized. Speakers included a member of Congress, a State senator, the mayor of the city, the juvenile-court judge, officials of labor unions, the dean of the school of social work, a chaplain from the veterans' hospital, who spoke for GI's on what they wanted for children and how day care fitted in. "Do you realize," one of the mothers remarked when the campaign for day care for children of Cleveland's working mothers was at its height, "what a community education experience this is for most of us? We could never have learned so much about our government and how it works and what is back of all our many welfare services."

How well do the mothers understand what they are asking for? While social workers have not been surprised that mothers should seek, with every means possible, to continue their program, some have been amazed at the clarity and effectiveness with which they have told what day care has meant to them and their children.

Child needs skilled guidance

There was the widowed mother who presented a graphic picture of her loss and loneliness at the death of her husband and of her effort to keep her home together through her work and the services of several housekeepers. These housekeepers could not understand her 4-year-old daughter's handicap, partial vision. They were making a "mental cripple" out of her by their well-meaning "Don't do this" and "Don't do that," for fear the child would harm herself. This mother told of the sympathetic understanding of her situation by the case worker and the thought that worker put into preparing the child for the day-care center. She could not say enough for the skilled guidance of the teachers, who let her child do most of the things other children did, even to climbing the "monkey bars."

"Where are our local social agencies in this picture?" another mother asks. "Don't they know that this is the best thing society has set up to meet our needs? They can't let it go. This is the best way of preventing juvenile delinquency I know anything about."

Another mother asks challengingly: "What if some of the parents aren't assuming all their responsibilities? You can't make them all over after they are grown up, can you? How does it help a child just to condemn his parents and try to get them to do things they can't do?"

Who needs child-care service?

"Certainly servicemen's wives need this," says one mother, "but some of the rest of us have needed a service like this, too." She is questioned by a mother who is not sure that they have a right to ask for a public child-care service for any child. Shouldn't it be for just those who need it? Promptly the questions pour in on this doubting mother: "But how do you decide who needs it?" From the heated discussion that follows, it is clear the majority believes that in a democracy the parent is the one to determine her own need and that of her child, and to decide the best way to meet such needs.

Emotional as well as economic needs are stated and recognized as a valid reason for a day-care service. "Isn't that why we have trained consultants on this program, to help us make up our minds what is best for ourselves, and then to stick by us if we have trouble carrying out our decisions?" Shyly, one mother volunteers, "We must tell people that the day-care center is a place for mothers, too. I know I'm a better mother than I used to be before Jean went there. I'm learning every day."

Still another mother, when asked what she had appreciated most about the service, thought it was the sympathetic, intelligent guidance of the teachers and the happy smile on her child's face as she left her in the morning. Then she added, "It's just everything about it; my child and I are both welcome; the staff is there for both of us."

Roles of teacher and case worker

Little persuasion has been needed to make mothers see the value of the teaching and child-development aspects of the day-care program. The role of the teacher who serves as a warm, friendly, experienced guide of a young child through most of his waking day is easily understood. The health aspects, too, are accepted. Even when vaccination or immunization causes havoc in a mother's workday schedule, the day-care center's right to be concerned with her child's health is usually welcomed. What is not so instantaneously understood or easy to interpret is the value of case-work service. From the start of the program, in one way or another, this service has been an integral part of the Cleveland program. Now, after nearly 4 years of experience and demonstration, this service has become so valuable to the mothers that in petitioning for the continuation of the program they have included it as one of the essential ingredients in a total day-care plan.

Most mothers know well that their young child requires a sense of security and belonging to an adult in the warm, affectional relationships of daily contacts. Meeting such a need is difficult when the parent who is the chief source of this affectional relationship is herself subjected to the threefold strain of carrying a job, managing her household, and caring for her child. Servicemen's wives have been carrying still another burden in their anxiety and fear over separation from their husbands. Furthermore, such women do not have the usual opportunities of young mothers to share with the father the normal anxieties and problems of parenthood. Even where the father is not in service, a third of our mothers using day care are separated, or divorced, or their marriages are acknowledged to be unstable.

These considerations make skill-

ful counseling by case workers vitally important all the time that a family uses the day-care center, but especially at the time of application. Here the groundwork of continued service is laid, and the mother is encouraged to understand that she may see this person from time to time as her need or her child's requires and to plan with the worker for his development.

At intake, the case worker helps the parent to weigh the values to herself and her child if she is embarking for the first time on a job outside her own home. Even where mothers have worked before, they have usually depended on a relative or friend or hired help for the care of their children, and have had little understanding of what the changes in this new form of child care will mean for themselves or their children. Just having the chance to talk over her need for a job and what the separation from her child will mean to both of them sometimes spares a mother and a child the stress and strain of embarking on a hasty and ill-thought-out plan.

The case worker and the head teacher, at intake, together have a chance to prepare both the child and the parent for the actual use of the service. The teacher and social worker give the parent detailed information about hours, fees, schedules, clothing, and medical care. The case worker handles any follow-up questions the parent may have about the day-care plan itself, and secures a picture of the child's developmental and social adjustment up to now.

Throughout the child's enrollment, the case worker is available to the parent for discussion of problems as they arise and for review of the day-care plan from time to time. No family situation remains static, and changes in any family set-up can alter the satisfaction of the child and parent in using the service. For example, a father may return home emotionally disturbed and shocked from the war, and a previously happy and well-adjusted child will show the stress and strain through which his parents are going.

At the time the child leaves the center, the case worker discusses with the parent what the ending of this experience means for herself and her child.

As a member of a team working with all the staff for the best use of day-care services by parents and children, the case worker serves as a valuable link between the center and the child's own home, helping to build up a mutually accepted and workable sharing of responsibility between both. When necessary she interprets community services to parents and helps them to find what services they may need from other agencies.

LEARNING TO PLAY HOSTESS, Lillie is passing carrot sticks to the other children at the day-care center. Bill can't make up his mind which piece to take. The center serves lunch as well as midmorning and midafternoon snacks.

OWI photo by Roscoer

Want voice in determining policies

Only a reprieve on the closing date of their emergency day-care program has been won by the Cleveland mothers who have so valiantly mustered to its defense, but their determination not to stop there continues strong. When they get their permanent program they want a voice in determining its policies.

They base their hopes for a long-range program available to any child who needs it, not only on their own efforts to interpret their need, but on the conviction expressed in the White House Conference report of 1940 which states: "Public child-welfare services should be available to every child in need of such help, without regard to legal residence, economic status, race, or any consideration other than the child's need. The local public welfare department should be able to provide all essential social services to children, either directly or through utilizing the resources of other agencies. Public and private child-welfare agencies should cooperate in a program which will assure the proper service to every child in need."

One mother sums it up: "In a democracy attention should be focused on the child. It is to this generation that we are giving the atomic bomb. We plan for day care with the full knowledge that a mother cannot give security to a child unless she has it herself."

Reprints available on request

PROTECTION OF MOTHERS AND CHILDREN IN PERU

by ANNA KALET SMITH
Office of the Chief, U. S. Children's Bureau

● **PROTECTION** of mothers and children in Peru, to which the Government of that country has been devoting much attention in recent years, made significant progress in 1940–44. Facilities for the care of maternal and child health have been expanded in Lima and other cities, and have been introduced in rural districts with rapidly increasing aid from the Government. For the greater effectiveness of the work, training has been made available for health and welfare workers, who are now employed in steadily growing numbers; and social service has been placed on a new basis, with help in one form or another extended to the family as a unit, instead of being limited to the individual applicant.

National Service for the Protection of Mothers and Children

The work that was previously centralized in the National Institute of the Child has been transferred to the newly organized National Service for the Protection of Mothers and Children (Servicio Nacional de Protección Materno-Infantil), which replaces the Institute. The National Service is the technical executive agency of the National Bureau of Public Health. It coordinates and directs health and welfare work for expectant mothers, babies, and young children, whether done by public or private agencies. It maintains prenatal centers, child-health centers, day nurseries, lunch rooms for mothers, and vacation homes for children. It also maintains such facilities as a school for mothers, a child-guidance clinic, a nutrition clinic, and a system of social service and legal aid to families.

The work of the National Service for the Protection of Mothers and Children is done through five divisions:

(1) The Division of Aid to Mothers directs the work of the prenatal clinics and lunch rooms for mothers in Lima and elsewhere and takes care of all matters relating to attendance at childbirth in the home. Under a new arrangement, aimed at meeting a very acute problem, midwives are employed by the National Service to attend at childbirth free of charge women who cannot pay a private midwife, or who for personal or family reasons are unable to go to a public hospital. A prerequisite for this form of aid is an examination of the prospective patient at a prenatal clinic during her pregnancy and an investigation of her case by a social worker. The midwife attends the patient not only at childbirth but also during the postpartum. The necessary medical supplies are provided at public expense.

(2) The Division of Child Health deals with the health of children from birth until the beginning of school attendance. This Division is particularly concerned with prevention of disease and the reduction of infant and child mortality. In an effort to achieve these purposes the Division has recently introduced in Lima an arrangement whereby health workers visit mothers and babies. Visits are made several days after birth to children who were born in the public maternity hospital in Lima (they represent 60 percent of the births in that city) and to those born in their own homes whose mothers had been attended by midwives of the National Service. The mothers are instructed in child care. Special attention is given to prematurely born infants, for whom incubators and other services are provided. The system of visiting is being extended to other cities as trained workers become more readily available.

(3) The Division of Public Health studies problems relating to family health and welfare. Much attention is given by this division to health education of mothers. At the "center of mothers' education" in Lima women and girls are taught child hygiene, dietetics, and sewing; individual advice is given on feeding children; facilities are available for immunizing children against infectious diseases; a library for parents and a permanent exhibit on child care are maintained. The mothers in some localities outside Lima receive health education from physicians, nurses, or midwives.

(4) The Division of Mental Hygiene of the Child is concerned with behavior problems of children. A child-guidance clinic has been operating in Lima as a part of this Division since 1943. Cases of mental defect and behavior problems are treated at the clinic, and parents are advised on the care and training of their children. Psychiatrists, a psychologist, a nurse, and social workers are employed. The latter visit the children's homes in an effort to ascertain the nature of the problem and to provide the treatment prescribed at the clinic.

(5) The Division of Social Service investigates the cases brought to its attention and aims to give economic, legal, and social aid to families and particularly to unmarried mothers. An important part of this Division's work is the placement of children who either have no homes or must be removed temporarily from their homes because of the mother's illness or for other reasons. Owing to recognition by social workers of the value of family life for children and also because of the shortage of institutions in Peru, most of these children are being placed in foster families. In some cases the children receive free care; in others, their board is paid from public funds, with their parents contributing according to their ability. The work of this Division has increased in Lima and has been extended to other parts of the country. Thirty so-

cial workers, graduates of the school of social service in Lima, were employed in that city at the end of 1944.

Facilities maintained by the National Service in Lima and Callao

In Lima the National Service for the Protection of Mothers and Children maintains the following facilities: A central dispensary, which includes an ear, throat, and nose clinic, an eye clinic, an X-ray department, a bacteriological laboratory, and a dental clinic; 19 health centers, some of which serve mothers and children, others children alone; 4 lunch rooms, 6 day nurseries, a central office of social service, a child-guidance clinic, a nutrition clinic, and a school for mothers. In Callao, the National Service maintains 5 health centers for mothers and children, a mothers' lunch room, a day nursery, and an office of social service.

Departmental Institutes of the Child

Outside Lima the National Service maintains Departmental Institutes of the Child in the capitals of 14 of the 22 departments into which Peru is divided. Nine of these institutes were established in the last 5 years. These institutes, which act as branches of the National Service, provide medical and other services for mothers—prenatal care, delivery, and postnatal care—and for infants and young children.

The institutes administer the work in the capitals and report on it to the National Bureau of Public Health. In some capitals they have introduced social services and have set up lunch rooms for mothers.

A CHILD-HEALTH CONFERENCE at Tamashiyacu, Peru, on the Amazon. It is part of the work of the Inter-American Cooperative Health Service.

C. I. A. A. Photo

Outside the capitals of the departments similar work, but on a more limited scale, is done in several cities and in some rural districts. The rural work is directed and supported by the Inter-American Cooperative Public Health Service. This cooperative service was established in Peru—and similar ones in several other countries—in accordance with a plan for the improvement of public health in individual countries, made at a meeting of representatives of the American republics in 1942. In each country agreeing to the plan, the service is financed jointly by the United States and the Government of the country concerned and is directed jointly by representatives of the two countries.

Child-health services by other departments of the Government

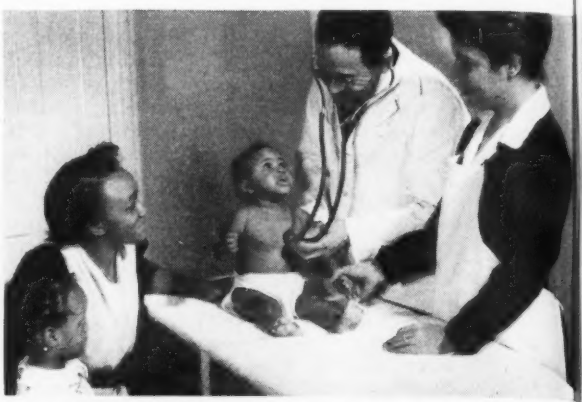
In addition to the National Service for the Protection of Mothers and Children other Government agencies are engaged in work for children. The Ministry of Education has recently embarked upon an extensive program of health work for school children, including regular medical examinations, dental services, and physical education; the Ministry of Justice maintains institutions for children presenting behavior problems; the Bureau of Social Welfare in the Ministry of Public Health and Social Welfare supports the Children's Hospital in Lima and several school-lunch programs in that city. Institutions for dependent children and hospitals and clinics for mothers and children, whether belonging to municipalities or to private organizations, are subsidized by the Government.

All this work now done in Peru on behalf of mothers and children is to be unified into one system after the expected enactment of the "Minors' Code," a draft of which has been recently sent to Parliament by the executive branch of the Government.

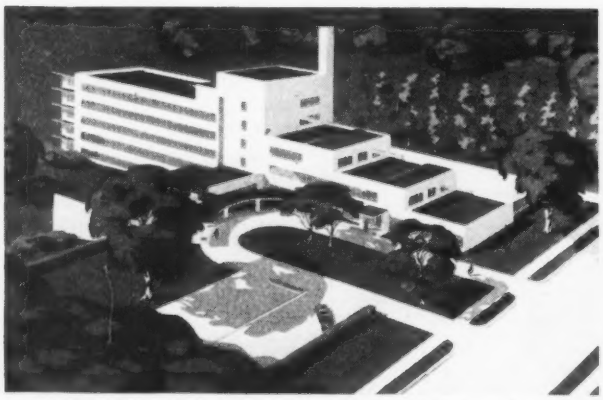
SOURCE: *Boletín del Servicio Nacional de Protección Materno-Infantil, Lima, January–June 1945*

TO MAKE 1946 A BANNER YEAR FOR CHILDRE

1 HOUSING that is fit for children, with adequate space for the whole family; good light, ventilation, and sanitation; and room for the children to play indoors and outdoors.

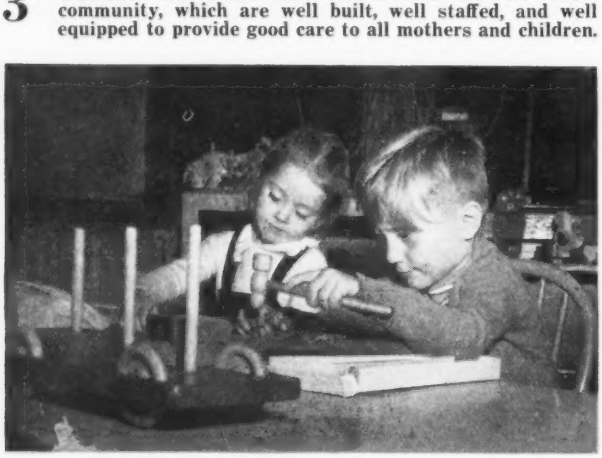


2 PRENATAL CARE for all mothers, and child-health serv ices for all infants and preschool children, to save moth ers' lives and give children a good health start in life.

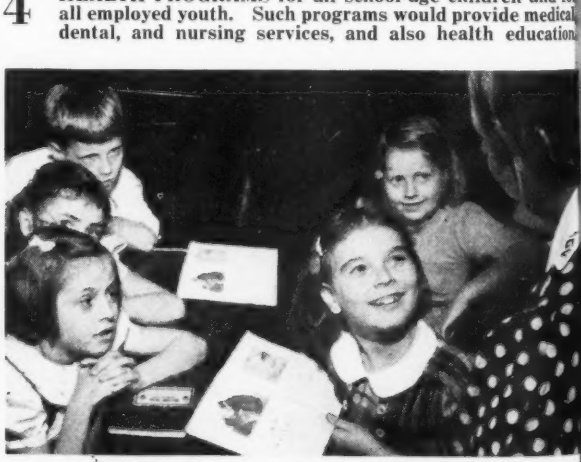


3 HEALTH CENTERS and HOSPITALS for the whole community, which are well built, well staffed, and well equipped to provide good care to all mothers and children.

4 HEALTH PROGRAMS for all school-age children and for all employed youth. Such programs would provide medical, dental, and nursing services, and also health education.



5 NURSERY SCHOOLS and KINDERGARTENS for children too young to go to regular schools with opportunities for happy, varied play under guidance of wise teachers.



6 SCHOOLING for all children and youth, with good buildings and equipment, well-prepared and well-paid teachers, full school terms, and well-rounded educational programs.

Here are 12 program ideas for citizens who want their communities to be a happy growing ground for all children and are willing to work to make them so

7 SCHOOL LUNCHES available to all school children, with good food that rounds out their day's food needs, and no discrimination between children who pay and do not pay.

8 RECREATION PROGRAMS FOR ALL AGES, with active games and quiet play, dramatics, arts, crafts, and music, and sympathetic adult supervision over these activities.

9 CHILD-WELFARE SERVICES, well staffed and with adequate facilities, for all children who are in need of special care in their own homes or in foster-family homes.

10 DAY-CARE PROGRAMS for children whose mothers are employed and for other children who require care away from their own homes during the daytime.

11 COUNSELING and CHILD-LABOR LAW ENFORCEMENT to help boys and girls prepare for what they want to do and find suitable jobs when ready for work.

12 GOOD LOCAL GOVERNMENT, concerned with the many problems and needs of children and youth, with opportunities for youth to share in some responsibilities.

SOCIAL WORKERS LOOK AT ADOPTION

Agencies helping unmarried mothers meet to criticize their own methods of work

• **RECOGNIZED** social agency or unauthorized intermediary—which of these two can best meet my needs?

This hypothetical question, posed by a hypothetical unmarried mother—and by persons seeking to adopt her child—was the central point of a recent panel discussion of the topic, "How can we achieve safer adoption policies?"

Participating in the discussion, which was held as part of the New York City meeting of the National Conference of Social Work, were social workers, a psychiatrist, a doctor, and a judge.

An abridgment of the discussion is presented here, without identification of the participants.

The lures of unauthorized adoption services

What are the lures of the unauthorized placement? The fact that a large number of unmarried mothers, and persons who wish to adopt a child, turn to unqualified intermediaries rather than going to a recognized social agency indicates that they may offer advantages. Which, if any, of these advantages can social agencies make their own without jeopardizing the quality of their adoption work as well as their service to unmarried mothers?

What attracts the unmarried mother to the intermediary? For the unmarried mother the intermediary offers quick service and confidential handling—a hurried protective process which assumes that secrecy is the one kind thing. Speed and secrecy—what enticing bait!

An apparent advantage may be the feeling of approval that a girl gets as the result of being praised for making the "best" plan for her child. It is "best," perhaps, only because it happens to fit in with the plans of the well-intentioned, or well-paid, intermediary.

Moreover, the urgent immediate need for quick return to normal living looms large in the girl's thinking and is seized upon by the unauthorized agency or unthinking intermediary to bring a quick decision to surrender the baby.

Another seeming advantage lies in the fact that the unmarried mother does not have to submit to what she considers "prying" into her life. She does not leave a record behind her which might jeopardize the secrecy of the whole procedure. The whole matter is ended, she believes, when the surrender is made, and there will be no follow-up to disturb her future and to remind her of the whole experience.

Finally, she may receive immediate cash assistance, which she often needs to meet expenses—the adoptive parents paying the bill and the intermediary frequently receiving the lion's share.

What attracts adoptive parents to the unauthorized agency? Again, speed and secrecy.

Who, with experience in adoption agencies, does not know the couple who suddenly decides it would be "just wonderful" to have a baby. Then, there is also the client who rightly complains that he or she has been to an authorized agency and has been waiting now for 2 years—the application is still pending because no child is available, or at least, not the right child.

The intermediary "solves" all such problems expeditiously. No time is consumed with exhaustive study of the personal life of those wishing to adopt a child. They come in for some of the same type of approval that the unmarried mother receives. They are also commended for their willingness to share their home with a child. They may be good people, it is true, but what matters is whether they will be good parents, and particularly, good parents to this individual child.

Do these lures offered by the intermediary have anything that social workers and social agencies should consider? Is it time for social workers to study their own philosophies and procedures? Are social agencies really meeting the needs of people? Or, for want of critical self-analysis, are they allowing these services, calling for highly specialized skills, to fall into incompetent hands?

Actually, social agencies should not only be able to compete with intermediaries but ought to be able to go them one better. If social agencies are not meeting their opportunity and their responsibility right now, the question is, why? Obviously, if social agencies were meeting the need, unmarried mothers would not be turning to intermediaries. Almost any unmarried girl would prefer the agency's protection to the other alternatives, if she knew about them and really understood them.

If social workers are to meet this situation and meet the intermediary on his own ground, they must be willing to say, "We will take this girl regardless of what her circumstances may be—a second baby—a married woman having a baby by another man—a girl without money—a nonresident—all of these girls and women, whatever their circumstances, will be cared for.

How intermediaries fail

Having a baby is a crucial experience—emotionally as well as physically—for a woman, be she married or unmarried. In addition to having the usual emotional attitudes toward pregnancy, the unmarried mother feels anxiety, guilt, and pressure.

As a group, unmarried mothers are frequently emotionally maladjusted, insecure, immature individuals with many conflicts. The crisis of illegitimate pregnancy renders them all the more so. Their future adjustment is jeop-

ardized by the added load of guilt, regret, and anxiety resulting from impulsive, badly advised, hasty decisions. Case-work help at each phase of the unmarried-motherhood experience can reduce its damaging effects on the personality. Adoption without such help fails to provide adequate safeguards.

The plans that are so often made abruptly and quickly through the intermediaries are made at just the time when the mother is least capable of exercising sound judgment in her decisions. A quick decision can be reached verbally and even acted upon, but it may take a lifetime of living with it to resolve it, and it may even prejudice the subsequent adjustment of the person who made it, not to mention the possible detrimental effect on the life of the child. Without leeway to act on a change of heart, particularly on a decision made before the baby's birth, tragic consequences to the mother, the child, and the adoptive parents may result.

The immediate postpartum phase is a most unfavorable time for making valid, important decisions. Nevertheless, because of many pressures—the demand for hospital beds, the urgency of the mother's own need for a speedy solution—the mother is almost blackmailed emotionally into using just that unfortunate moment to make such a vital decision. Vulnerable and threatened because of the predicament created by violating accepted social mores, she is particularly apt to turn frantically for direct advice to friends, family, and other well-meaning—or not so well-meaning—amateurs who are often all too ready to urge a hasty plan upon her.

The unmarried mother should have protection and time—time to work out a decision with the greatest possibility of its being the wisest one for her and the baby, and with a minimum of later destructive repercussions. Not only does she need time, but during it, she should have somebody to whom she can turn for guidance who is objective, impartial, and accepting. Friends and relatives are of necessity limited in their objectivity in such a situation. The trained case worker, on the other hand, is able to meet these needs by offering practical help of various kinds; and at the same time she can assist the girl or woman in finding and carrying out the best plan in the light of her own true feelings and individual situation.

Another very important aspect, largely ignored by an unauthorized person, is the protection of the baby, whose lifelong welfare is at stake. Relief from guilt and ostracism may be won by the mother at the expense of the child's future. Appropriate case work treatment of these mothers in many instances resolves these unconscious conflicts and feelings of guilt and tension without sacrificing the welfare of the baby.

Training and special skill are needed also to evaluate the deeper reasons underlying the decision by couples to adopt a child. The wish to adopt is usually rooted in multiple motives, often contradictory, of different degrees of awareness, and not all are conducive to the best interests of the child or the adoptive parents.

Social agencies must not only concern themselves with what the motives for adoption are but also their relative proportions in a given instance.

In what ways do social agencies fail?

Social agencies need to subject themselves and their procedures to honest self-scrutiny. Do they on occasion exhort the individual seeking help "to be realistic" when in reality it is a rationalization on the part of the worker—an expression of punitive attitudes, conscious or unconscious? Isn't the term "realistic" often invoked as a barricade, shielding the worker from acknowledging inadequate resources with which to meet the client's needs? In such instances, is it not the social agency which is being unrealistic?

Since social workers themselves are products of the culture in which rejecting and punitive attitudes prevail against unmarried mothers and their babies, they need to be especially alert to maintain the objectivity essential to all areas of social work, and to guard against subtle, disguised intrusions of their own needs and attitudes into their professional practices.

Some current restrictive and truly "unrealistic" agency policies arose, and are maintained, to some extent at least, by such hidden penalizing attitudes. For example, there is the girl's frantic desire for anonymity. This is denied her by procedures whereby she is forced to reveal her story in many different quarters. Or an agency fails to recognize the urgency of her needs. An appointment set for 2 or 3 weeks hence to a desperate girl facing an immediate crisis cannot successfully compete with private adoption. Nor can her impatience be branded as "immature intolerance of realistic delay." Rather, agencies must acknowledge that their facilities for emergency care are deficient, and make efforts toward correcting them.

The dilemma of maintaining high clinical standards in the face of pressure for speedier solutions may be met to some extent by learning better diagnostic differentiation among clients so that a wider range of types of help can be offered, based on clinical knowledge of the indications for each. Although all unmarried mothers, in this society, are apt to present personality maladjustment, the degree of this varies enormously.

One type of girl will have greater conflict and mixed feeling entering into all her reactions and decisions and will need more therapeutic help and longer time to work out her plans. Another type of girl, however, less divided against herself and capable of more mature judgment, can reach final decisions more rapidly and may be best served by quicker, more direct, and specifically limited forms of assistance. A girl of the latter type is often driven to independent placement when a social agency mistakenly brushes aside her repeatedly expressed preferences for adoption and persistently emphasizes helping her to "find out what she really

wants." It seems almost as important to recognize and accept the capacity for valid self-direction as the lack of it.

Unmarried mothers have in common only the one fact—their illegitimate pregnancy. Otherwise they represent a gamut of personality structures and of socio-economic and educational backgrounds; they differ in race, religion, and temperament, and in clinical psychiatric diagnosis. Such different people need different kinds of help.

If policies become rigidly fixed, without consideration for divergent needs, there is danger that punitive attitudes and procedures will counteract what would otherwise be helpful measures.

Although direct financial assistance to these women is often regarded as a questionable practice, for certain individuals it is undoubtedly desirable. This need for money has particular significance, for in resorting to private adoption, the girl's acute financial plight is often the deciding factor. Case work should be solid enough to determine the need.

Social agencies must consider, too, whether they are really living up to their promises to keep the girl's story secret if she must tell it to half a dozen different people in the course of working out the problem.

For example, in some instances the unmarried mother comes to the emergency desk of the hospital for help; the hospital refers her to the shelter agency; the shelter agency refers her to the department of welfare. Then she is referred to the adoption agency; then to the hospital and the hospital social worker. If there are paternity proceedings she goes to yet another person. If she wants to place the baby in a foster home there is yet another one. Each time she must repeat her story. Upon the girl who is already confused is projected the confusion of the various agencies.

About all social agencies can do to counteract this situation is to make their referrals very clear, prepare the girl for them, and simplify them as much as possible.

The transfer of a baby to an individual or an unauthorized agency for placement occurs about the time that the baby leaves the hospital, and for that reason the role of the hospital in placement is highly important.

The hospitals and their responsibility

Hospitals are beginning to realize that their responsibility and, as a matter of fact, their duty should extend beyond the actual physical or medical care that they render to the mother and baby.

There is, however, a justified criticism of social agencies on the part of doctors—that is their feeling that perhaps too many hurdles and too many obstacles are put in their path, or the path of their patients, in trying to arrange care through the social-service department of the hospital. When the administrator of a hospital questions the social-service department, it becomes obvious that many of these restrictions or obstacles are placed there by the so-called recognized agencies. The administrator is, therefore, still at a loss as to how to expedite the process so that the mothers and babies are well served.

Safeguarding adoption

A vast proportion of the children of unmarried mothers are placed permanently in homes without any of the safeguards that are placed around children who are temporarily placed away from their own homes. What seem to be good procedures for adoptive placement have been carefully worked out by child-placement agencies and yet a vast majority of the children who are adopted do not benefit by these procedures.

One of the first questions has to do with existing legislation and its inadequacy in protecting the child placed independently.

Such a child will be in the foster home before any social agency enters the picture. The investigation, under such circumstances, can only be made with the idea of approving the adoption if it is humanly approvable. Otherwise the only home which the child has really known is disrupted, together with the lives of the foster parents. Once the child has been placed it is too late to deal effectively with such questions as: Is this a child who should be placed for adoption? Is this a home into which a small child should be placed? Is this the home for this particular child? Social agencies are handicapped in answering such questions if they look into the home 6 months or a year after the placement. Their investigations, their judgments, are made when it is too late for them to be real judgments.

Some States are beginning to grapple with the problem and are trying to meet it. In many States there is no legal requirement to safeguard the child, the natural parents, or the foster parents.

The time has come when States should look at this whole situation and see what kind of legislation can be helpful to secure certain safeguards for everyone concerned.

Definitive solutions to this complex problem have not as yet been attempted. However, social workers are the professional group most competent to assume responsibility for leadership in social planning and practice in this field of adoption.

As the public understands the weaknesses of the service offered by intermediaries, profiteers, and traffickers in this field, it will tolerate them as little as it does incompetent practitioners in medicine and law.

Within the professional fields themselves, the need for recognizing and separating out the specific contribution of each professional group involved is apparent. These groups must be encouraged to pull together toward safer adoption practices. If medicine, law, hospital administration, and social work will each study means for improving its own part of this work, this goal will be relatively easy to achieve.

A more complete report, 36 pages mimeographed, may be obtained at 25 cents a copy from the office of the Welfare Council of New York City, 44 East Twenty-third Street, New York City. For 10 or more copies the charge is 20 cents each.

HELPING THE HARD-OF-HEARING CHILD

Crippled children's agencies plan new services to give these children a better chance

by *ARTHUR J. LESSER, M. D.*

Health Services Division,
U. S. Children's Bureau

● **EVENTS OF THE PAST** few years have led to considerable emphasis on the national problem of handicapped persons. The results of the physical examinations made by selective-service boards have brought into prominence facts about the health of our youth which have been more or less generally known but which have acquired a new importance because of their relationship to the requirements of national security.

Hearing tests alone insufficient

Interest in the child with impaired hearing was stimulated a few years after the First World War by the development of the "4–A" audiometer, which facilitated the testing of children in groups. School systems, especially in the cities, have developed procedures for the periodic testing of school children and for evaluating special educational requirements for them. In some of the city-school health programs provision is made for the examination of selected children by an otologist. The inadequacies of programs of this type lie chiefly in the failure to provide for the medical care and the rehabilitative measures that may be needed.

The shortcomings of case-finding surveys which do not provide for remedial services are well illustrated by a recent study of the school health-examination records of a group of men rejected for military duty.(*1*) This reveals that a relatively large number of the defects causing the rejections had been present in childhood and had been noted on the school records. Many of the defects were of the kind that are preventable or could have been corrected. This exemplifies a common situation in our school health programs—an emphasis on the discovery of defects but a lack of effective planning to correct such defects or prevent their progression.

Surveys of hearing tests show that 4 to 6 percent of school children have impaired hearing. Six percent is the figure arrived at in a recent statistical review of such tests, including 1,079,168 pupils in 30 States tested by the group audiometer during a school year.(*2*)

There are a few indications that defective hearing is more extensive in rural than in urban areas. A hearing survey in Minnesota revealed that about 14 percent of an unstated number of rural school children had a significant hearing loss as compared with 5 percent of Minneapolis school children of the same age, with the same technique of testing employed.(*3*) In Delaware, among 1,386 children attending rural schools having from one to four teachers, 11 percent were found to have a significant hearing loss, compared with an incidence of 6 percent among 10,100 Wilmington school children.(*4*)

A concern of every community

Regardless of variations reported in the incidence of hearing impairment, enough facts are available to show that this is a serious problem affecting children in every community, a defect that is frequently progressive and which affects the child socially, psychologically, and financially as well as physically. Since much hearing loss is preventable, it is pertinent for us to ask what is being done in our communities to prevent deafness and to care for children who have a loss of hearing. It is obvious that if a program of hearing testing is to be of more than statistical value, it should be regarded as only a preliminary step toward establishing a comprehensive plan for the medical care, education, social adjustment, and general rehabilitation of children who are found to be handicapped.

The remedial problems of many children with loss of hearing are complex and often frustrating. For some hard-of-hearing children medical treatment can accomplish little, and emphasis must be directed toward general rehabilitation. These difficulties have recently been somewhat obviated. The development of more efficient hearing aids has made it possible to provide improved hearing for many children in need of help. The dramatic results in therapeutics being achieved with the sulfonamide group of drugs and penicillin in controlling infections of the ears that often result in impaired hearing have been a prominent factor in vitalizing interest in the prevention of deafness.

Hope for prevention of deafness

It is, after all, in the prevention of deafness that our greatest hopes lie, and now medical resources are available which make it possible to implement effectively an educational campaign for prevention.

Here is a group of children in whose welfare interest is widespread. Scientific methods of locating them are in general use, better appliances for providing improved hearing for many are available, methods of speech conservation and of instruction in lip reading have been developed in the schools, and medical measures for the prevention of much hearing loss now appear to be a reality. The methods therefore are now available by which a comprehensive program for the hard-of-hearing can be developed.

Such a program, of course, requires the cooperative efforts of public and private agencies in various fields, such as State and local departments of health, education, and welfare, and societies for the hard of hearing. It is prob-

ably best developed as part of the State crippled children's program, in a local area with an organized health department, where it is possible to make provision for medical and hospital care, public-health nursing, medical-social services, and general rehabilitation. It should be conducted in cooperation with the educational authorities.

The largest source of cases will be found in the schools through hearing tests. In communities where periodic testing has been done, many hard-of-hearing children will already be known to the schools. In testing the hearing of school children, it is desirable to include the retesting of pupils in the schools for the deaf, since children may be found in these schools who can attend regular schools if properly fitted with hearing aids and taught lip reading. Of course, preschool children will not be reached by school testing, and therefore reliance must be placed on referrals from other sources, particularly public-health nurses and parents. This is an important group to reach inasmuch as preschool children are often more adaptable to their handicap than older children and, moreover, impairment of hearing often occurs early in life and affects adversely the development of speech.

Federal-State programs begun

The Children's Bureau is now cooperating with two State crippled children's agencies in developing programs for children who have impaired hearing. Owing to limited funds only a few localities in these States are being served.

Medical services in the Federal-State programs are provided by qualified otologists in clinics conducted by the official State agency, and in hospitals. In addition to the otological examination individual hearing tests are performed. Provision is made for whatever treatment is needed, whether in the clinic or in the hospital. It should of course be hardly necessary to point out that in any specialized service a thorough general pediatric examination is essential.

One of these programs is giving particular attention to a group of children whose hearing deficiency is believed to result from secondary changes in the middle ear following obstruction of the Eustachian tube. Examination of the area around the opening of the Eustachian tube often reveals an overgrowth of adenoid tissue, which may obstruct the opening of the tube. If this is not treated, the hearing may become impaired. Treatment of the adenoid tissue by a radioactive substance called radon usually reduces the mass of adenoid tissue. A study is being made in this program of the incidence of this condition in causing hearing impairment and of the efficacy of radon in preventing loss of hearing.

Clinics for the hard-of-hearing

A clinic for hard-of-hearing children, particularly if serving a rural area, will usually be found to supply a long unmet community need. Indeed, in one of the programs it has been difficult for the clinic to meet the many requests for services coming from public and private agencies and from referring physicians. A large number of the children being referred to this clinic have varying types of nose and throat conditions which may have only a remote relation to hearing. This program has demonstrated, in an average rural county in the East, how well received is a highly specialized service of this type. Obviously, the need for this service in this country is great, dealing as it does with a variety of conditions which are largely subacute or chronic and which present obstacles both to treatment and to rehabilitation. The condition that leads to impairment of hearing often causes no serious discomfort and may lend itself to adjustment by the person, but frequently progresses until a disabling condition has been established.

The clinic or health center also serves as the center for an educational drive among the public, the schools, and the medical profession against loss of hearing. The prospects of preventing much of the hearing loss that results from infections such as otitis media, mastoiditis, and meningitis appear to be good. The recent remarkable results achieved in controlling infections by the use of the sulfonamides and penicillin will probably effect a considerable reduction in the number of children who have lost their hearing as a result of ear infections. The widespread use of these drugs has resulted in a considerable diminution in the number of children developing mastoiditis and chronic otitis media. There seems to be no doubt that good medical care in acute otitis media will prevent the development of a large percentage of new cases of deafness annually. However, the weekly or monthly otology clinic alone cannot accomplish this. The responsibility for this must lie with the family, the schools, and the community in recognizing the importance of prompt medical treatment of acute otitis media. The preventable nature of certain types of deafness must be emphasized and the information widely disseminated. Here the role of the public-health nurse is of utmost importance in view of her knowledge of family situations and her repeated visits to families and conferences with teachers regarding their pupils.

Needs of various children

Some children should be fitted with individual hearing aids by an otologist or a qualified assistant. For many the regular school program should include speech conservation and instruction in lip reading, given by special teachers under the general guidance of local and State educational authorities. Many State and city school systems now have departments of special education, one of the responsibilities of which is to plan and direct adjusted educational programs for handicapped children, including those with defective hearing.

Speech conservation and instruction in lip reading are important even for children with a mild degree of hearing loss. In fact, when hearing becomes impaired some children automatically begin to watch the movements of people's lips as an aid to hearing. This natural tendency should be guided

by training. Whether training in speech and lip reading alone will suffice or whether this training should be given in conjunction with the use of a hearing aid will depend on the degree of hearing loss. This decision requires a careful and detailed evaluation of the child's disability and of his accomplishments in speech and hearing.

In many cases provision of hearing aids and instruction in lip reading will not be enough. Older children particularly are apt to have great difficulty in accepting the fact that their hearing is permanently impaired and that a measure of restoration can be found only through wearing an appliance. The seriousness of many adolescent children's reaction to the information that nothing further can be done to restore hearing must not be underestimated. For many the psychological impact is as serious as that occurring in cases of blindness. For such children this is the point at which the program can be considered a success or a failure. It will tax the skill and patience of the physician, and of the child's teacher, the public-health nurse, and especially of the medical-social worker to help these children in accepting their handicap and making a good adjustment to it. Resistance to wearing the hearing aid sometimes may be one manifestation of a more general problem in adolescent personality adjustment. In such instances the help of a child psychiatrist often proves most valuable. Working with the parents becomes just as important, for they must be assisted in overcoming their fears with regard to the child's school and social adjustment and his future capacity to be self-supporting.

Start restoration measures early

The feeling of inadequacy and the emotional conflicts encountered among adolescents with impaired hearing can be largely prevented by starting restoration measures early in childhood whenever these are needed. The delight and enthusiasm that young children display when they are assisted in hearing by an aid is often in sharp contrast to the reluctance to use an aid shown by older people. Much of the trouble in school, the repeating of grades, the problems with other children, which constitute tragedies in hard-of-hearing children's lives, may be avoided by early treatment.

Instruction of young children in lip reading and the use of hearing aids has permitted many who have severe hearing loss to progress normally in regular schools. Segregation of deafened children in special schools is necessary only for comparatively few. Efforts should be made to assist the child so that he can attend school with normal children, since most handicapped children progress better and are happier when they can associate freely with normal children. The value of hearing aids for young children probably has not been fully realized, but if children are to make the best use of the degree of hearing left them, more extensive use of aids and lip reading in properly selected cases is essential. This will give many of these children equal opportunities with others in schools and in adult life.

(*1*) Ciocco, Antonio, Henry Klein, and Carroll E. Palmer: Child Health and the Selective Service Physical Standards. Public Health Reports, Vol. 56, No. 50 (December 12, 1941). Pp. 2365–2375.

(*2*) Berry, Gordon, M. D.: Deafness in the United States; a statistical review. Volta Review, Vol. 40, No. 2 (February 1938), pp. 69–71; 120.

(*3*) Hearing Problems in Education, by Horace Newhart, M. D. Journal of the American Medical Association, Vol. 109, pp. 839–841 (September 11, 1937).

(*4*) An Investigation of the Acuteness of Hearing of Children in the Delaware Public Schools by Means of the 4–A Audiometer (Phono-Audiometer), by Virginia S. Wallin and J. E. Wallace Wallin. Board of Education, Wilmington, Del. Processed. 64 pp.

Reprints available on request.

JOHNNY'S TEACHER is testing his hearing with an individual audiometer. He has previously been tested with his classmates by means of a group audiometer, and the group, or screening, test showed that his hearing was impaired. The individual test will give a much better idea of the extent of Johnny's hearing disability and what help he needs.

Photograph by Look Magazine

Photograph by Look Magazine

COUNSELING YOUNG WORKERS

by *JANE F. CULBERT*

Vocational Advisory Service
New York City

• **GOOD VOCATIONAL** counseling is always personal; it never loses sight of the many-sided individual who is seeking advice, nor the fact that it is dealing with a growing, developing human being.

No set of rules, no equipment will enable a counselor to assign a person automatically into one or another vocational niche. Though the beginning worker may be one likely to do well in certain kinds of jobs because, for example, he has excellent finger dexterity, or facility with numbers, he may have so much more interest in another line of work that it would be unwise to urge him into a field to which he brings less interest. The good counselor knows that most people have a sufficient variety of abilities to succeed in more than one line, and that a man's greatest ability multiplied by little interest may not bring so high a product as his maximum interest multiplied by his second or third set of abilities.

Ability to understand the individual, to find out who he really is, to help him express his interests, aims, and hopes, and to evaluate them, is a primary requisite of the good counselor.

Wide background needed

However, he must also have a wide background of information and experience so that he may be able to see where the young person could utilize his interests. He must know the demands made in various fields of work, and be able to judge whether the environment of a certain line of work would be congenial and to evaluate the suitability of a given type of work for a specific individual, and also to take into consideration the background of each individual, if he is to do more than give information about work fields or training.

A good counselor uses all practical aids to understanding the person that are provided by the community. He will maintain active relationships with community agencies, for both the information that they supply and the service that they render, to supplement the social and recreational life of young people who need development along these lines to help them achieve a satisfactory personal life and to add to their employability.

The counselor will need to be in touch with such agencies as the employment service and with the chamber of commerce or local business groups, in order to keep abreast of employment changes and opportunities.

Aptitudes not only factor

Psychological tests will be used by the counselor, whether these are given through his own agency or through other community resources. He will make sure that tests are reliably and professionally given and that they are properly interpreted. Moreover, he will use the interpretations of these tests only as one source of important information about the individual's abilities, since, as has been suggested, interests, personality, and other factors, as well as many practical considerations, are important along with aptitudes.

A good counselor will help the young worker to understand the situations that he will find in beginning jobs and the way in which he may draw from even limited situations information that will be valuable to him later.

It is more important in beginning placements than in those for experienced workers that the placement be made with a view to the young person's social and personal limitations, needs, and strengths. Of two young people, each with the same kind of clerical ability, one may be very happy working alone in an office, with responsibility for a certain set of routine tasks; while another will be discouraged from all clerical work unless the job provides some companionship and a variety of duties.

The experienced worker can see how he fits into the whole organization, and can see possible lines of advancement, where the young worker cannot.

No matter how experienced, the counselor will not expect to know everything about the occupations and training resources applicable to a given situation, nor yet about the young person before him. He knows that it is no reflection upon himself if he cannot give immediate answers to all the questions that are raised, either about the occupations under discussion or their suitability for the applicant at the moment.

When dealing with adolescents, he will always keep in mind that he is dealing with enthusiasms that may shift again and again in quick succession. Though these may not safely be regarded as direct indications of future vocations, they must be seriously considered as clues to the type of work, activities, or social and emotional needs which must be represented in the plan if it is to be accepted and if it is to "take." Good counseling ordinarily does not assume a final answer for the young person. Rather, it gives a sense of direction and opens possibilities.

A good counselor will have the habit of reflecting upon the problem, taking time to see the relationship between the various factors that enter into it, and being sure that his advice is in line with the young person's development and is not merely an immediate answer, which, taken alone, might lead him astray.

Finally, good counseling cannot be done on a mass basis. The experienced counselor knows that hurried or superficial work is not sound, either for the applicant or for the agency, and will therefore not accept more cases than he can handle adequately, even though some young workers will have to do without his services.

Miss Culbert writes from many years' experience as director of the Consultation Service, a vocational-counseling service for young people conducted jointly by the Vocational Advisory Service and the U. S. E. S. Employment Office in New York City.

Reprints available on request

U. S. GOVERNMENT PRINTING OFFICE: 1946